Nevada State Veterans Home **Section IV**

Physician's Medical Certificate

This Certification is Valid For Three Months Please print

I certify that _____
Last Name First Name Middle initial

requires 24-hour skilled nursing care. _____ _____
Physician's Signature *Date of Exam*

Date of Birth ____/____/____ Age _____ Social Security # _____-____-_____

Male ☐ Female ☐ **Allergies:** _____

_____

Current Diagnosis: _____

_____

Other Pertinent History: (include past medical problems, complaints, etc.)

_____

_____

_____

_____

Hospitalization and operations for past 90 days:

_____

_____

Physical Examination: Height _____ Weight _____

Temperature _____ Pulse _____ Respiration _____ B/P ____/____

Skin Condition/Pressure Areas: Please describe condition, site, stage, etc. _____

_____

_____

Current diet: _____

Significant other positive findings:

_____

_____

Section IV

PHYSICIAN'S ASSESSMENT FOR CARE PLANNING

PLEASE CHECK APPROPRIATE BOXES BELOW

Level of consciousness:

Alert ☐ Yes ☐ No Comments _____

Withdrawn ☐ Yes ☐ No Comments _____

Confused ☐ Yes ☐ No Comments _____

Oriented as to: ☐ Person ☐ Place ☐ Time
Memory Impairment: ☐ Mild ☐ Moderate ☐ Severe
History of wandering behavior, gets lost: ☐ Yes ☐ No
Comments _____

Communication ability:

Can Speak ☐ Yes ☐ No Understands Speech ☐ Yes ☐ No

Can Write ☐ Yes ☐ No Speaks Clearly ☐ Yes ☐ No

Can Hear ☐ Yes ☐ No Understands Writing ☐ Yes ☐ No

Hearing Aide ☐ Yes ☐ No Understands Gestures ☐ Yes ☐ No

Vision: ☐ Adequate ☐ Moderately Impaired ☐ Wears Glasses ☐ Severely Impaired

Personality or behavioral problems: ☐ Yes ☐ No

If yes, please explain _____

Physically or verbally abusive: ☐ Yes ☐ No

If yes, please explain _____

History of alcohol abuse: ☐ Yes ☐ No Explain: _____

History of drug abuse/use: ☐ Yes ☐ No Explain: _____

History of dementia: ☐ Yes ☐ No Explain: _____

History of psychiatric illness: ☐ Yes ☐ No Explain: _____

History of medication or medical non-compliance: ☐ Yes ☐ No

History of falling or injury secondary to falls: ☐ Yes ☐ No

History of: ☐ delirium ☐ confusion ☐ agitation

Section IV

PHYSICIAN'S ASSESSMENT FOR DAILY LIVING ACTIVITIES

PLEASE CHECK APPROPRIATE BOXES BELOW

Bathing
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance

Grooming
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance

Dressing
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Needs total assistance

Feeding
- ☐ Completely independent
- ☐ Needs assistance
- ☐ Must be fed
- ☐ Has swallowing disorder
- ☐ Unable to prepare own meals

Medication
- ☐ Needs assistance
- ☐ Incapable of taking own meds
- ☐ Able to take own medication

Ambulation
- ☐ Can walk _____ yards
- ☐ Can climb stairways
- ☐ Requires wheelchair
- ☐ Requires assistive devices such as cane walker, electric cart, motorized wheelchair prosthesis. *(Circle all that apply)*

Transfer
- ☐ Can transfer to bed, chair, toilet
- ☐ Uses aides for incontinence

Toilet
- ☐ Completely independent
- ☐ Uses aides for incontinence
- ☐ Occasionally wet and soils self
  - ☐ 1 x day ☐ 2 x day ☐ More often

Is this applicant's medical condition such that he/she is capable of conducting his/her own affairs.

Yes ☐ **No** ☐

_____

_____

Physician's Name _____ License No. _____
(please print)

Physician's Signature * _____

Address _____
(Street) (City/State) (Zip)

Telephone (____) _____ Fax (____) _____

Date signed _____

***NOTE:** **If this evaluation is being performed by a physician assistant or nurse practitioner, it must be counter-signed by a Physician/MD.**